

# DIAGNOSTIC RADIOLOGIC SCHOOL APPLICATION

## Application for Approval of School Teaching

### Diagnostic Radiologic Technology

**Please Return the Completed Application To:**

California Department of Health Services  
Radiologic Health Branch/Certification  
P.O. Box 942732, MS 178  
Sacramento, CA 94234-7320

#### IDENTIFICATION

Name of school or sponsoring institution		Telephone number (      )      Ext.	
Address (number, street)	City	County	ZIP Code
Name of administrative head	Title		
Director of the course of study	Title		

#### Indicate qualifications

- ☐ Radiologist certified by the ABR     
 ☐ Certified Radiologic Technologist     
 ☐ Radiologic Physicist certified by the ABR  
☐ Other (explain): \_\_\_\_\_

#### CURRICULUM

1. Is your school's curriculum in writing? <input type="checkbox"/> Yes <input type="checkbox"/> No    If copy not attached, please explain: _____	2. Total length of training—months
3. Indicate <b>total hours</b> of training in the following areas:	
_____ Formal classroom instruction	Laboratories: _____ General radiographic
_____ Radiation protection	_____ Supervised clinical education
_____ Seminars, discussions, demonstrations	_____ Radiation protection
	_____ Other (specify): _____
	_____ Positioning

#### ORGANIZATION

1. Indicate type of school. <input type="checkbox"/> Public community or junior college <input type="checkbox"/> Hospital <input type="checkbox"/> Other (explain): _____	
2. Indicate teaching time. <input type="checkbox"/> Day school only <input type="checkbox"/> Evening school only <input type="checkbox"/> Both day and evening school <input type="checkbox"/> Quarter system <input type="checkbox"/> Semester system <input type="checkbox"/> Continuous <input type="checkbox"/> Other (explain): _____	
3. School year Starting month: _____ Graduation month: _____	4. Accreditation Is your school accredited by the AMA Council on Medical Education? <input type="checkbox"/> Yes <input type="checkbox"/> No Type and length of approval: _____
5. Affiliation—name(s) of affiliated hospital(s) or college(s) ( <i>NOTE: Please complete clinical training facilities form for each affiliated hospital.</i> )	
6. Indicate degree or certificate granted.	7. Does your school have an active advisory committee? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, attach a list of members.

#### RECORDS

	Yes	No		Yes	No
1. Are all administrative policies clearly stated in writing and maintained in the administrative records?	<input type="checkbox"/>	<input type="checkbox"/>	5. Are all records of individual students maintained showing the following?		
2. State your school's policy in keeping and issuing transcripts.			Attendance	<input type="checkbox"/>	<input type="checkbox"/>
			Grades	<input type="checkbox"/>	<input type="checkbox"/>
			Teacher's observations	<input type="checkbox"/>	<input type="checkbox"/>
			Clinical experience record	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you keep records of the following? Agreements with other schools, agencies, organizations All correspondence with the State Department of Health Services Course outlines of all Radiologic Technology courses	Yes	No	6. Student progress evaluation	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>	Is progress of each student evaluated at the end of each teaching unit?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Is evaluation done at midterm?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Does the evaluation consist of written exams?	<input type="checkbox"/>	<input type="checkbox"/>
4. Indicate your school's admission policy. High school diploma required Acceptance by the admission committee Other requirements (please explain): _____	Yes	No	Do you keep copies of the content of all final exams?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	List other forms of evaluation: _____		
	<input type="checkbox"/>	<input type="checkbox"/>	_____		
	<input type="checkbox"/>	<input type="checkbox"/>	7. Are you in compliance with state regulations regarding radiation protection?	Yes	No
			<input type="checkbox"/>	<input type="checkbox"/>	
			8. Radiation protection officer—name/title		

## FACULTY

1. List names and academic titles of all instructors teaching diagnostic radiologic technology or subjects related to radiologic technology.

Name	Degree	Title	Teaching Credential	Radiologic Technologist Certificate Number

2. Do you keep the following records on each teacher?

Yes No

Workload by subject	<input type="checkbox"/>	<input type="checkbox"/>
Hours taught	<input type="checkbox"/>	<input type="checkbox"/>
Percent of full-time teaching	<input type="checkbox"/>	<input type="checkbox"/>
Percent devoted to administrative duties	<input type="checkbox"/>	<input type="checkbox"/>
Subjects taught in the past	<input type="checkbox"/>	<input type="checkbox"/>

## FACILITIES

1. Instructional facilities—describe rooms used for radiologic technology training—number, size, and use.

2. Classroom equipment	Yes	No	3. Reference library—does the library have:	Yes	No
Are classes equipped with a chalkboard (blackboard)?	<input type="checkbox"/>	<input type="checkbox"/>	Up-to-date standard textbooks and reference materials on radiologic technology?	<input type="checkbox"/>	<input type="checkbox"/>
Are enough seats provided for all students?	<input type="checkbox"/>	<input type="checkbox"/>	Periodicals on radiologic technology?	<input type="checkbox"/>	<input type="checkbox"/>

4. X-ray equipment—Describe diagnostic x-ray equipment your school possesses.

	Max kV	mA
	Max kV	mA
	Max kV	mA
	Max kV	mA

5. Describe film processing equipment.

6. Describe facilities used for laboratory demonstration and practice.

7. Describe phantoms available.

8. List audiovisual aids available.

**ENROLLMENT**

1. Number of students in the following categories:

_____ Total	_____ Expected to graduate each year
_____ Day classes only	_____ Maximum the program could accept each year
_____ Evening classes only	_____ Maximum the school can accommodate at any one time
_____ Day and evening classes	

2. Estimated number of applications for admission received per month

3. Number of applications for admission received in previous year

**SUPPLEMENTS**

Please append to this application one copy of the following material:

	Appended	Not Appended
1. School catalog or bulletin	_____	_____
2. Blank application form for admission	_____	_____
3. Graduation certificate marked "copy"	_____	_____
4. Forms used for records and evaluations	_____	_____
5. List of course textbooks, references, and periodicals	_____	_____
6. Joint review committee accreditation	_____	_____
7. Course descriptions, curricula, and study plans	_____	_____
8. All affiliation agreements, properly signed	_____	_____
9. Radiation protection course outline	_____	_____
10. Advisory committee—composition and function	_____	_____
11. Transfer credit policies	_____	_____

**ATTESTATION**

Name of person completing this application

**Oath: I certify that, to the best of my knowledge and understanding, the foregoing is true and accurate and, further, that the school meets the standards stipulated by California Laws Relating to Radiologic Technology and the implementing regulations.**

Signature of administrative head or director of the school

Title

Date



## CLINICAL TRAINING FACILITIES

[illegible]